

FILED DEC 30 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42882  
10900

BIRTH NO. <u>9.3574-54</u>		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>10900</u>											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE				b. COUNTY									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>				c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Ann's 1071</u>											
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Saint Louis Maternity</u>				d. STREET ADDRESS (If rural, give location) <u>3609 St Gregory Lane</u>													
3. NAME OF DECEASED (Type or Print)			a. (First)			b. (Middle)			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year)					
									<u>Thompson</u>			<u>November 16 1954</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>November 16 1954</u>			9. AGE (In years last birthday)		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours				
													<u>8 35</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and State or Foreign Country)				12. CITIZEN OF WHAT COUNTRY?					
								<u>St Louis Missouri</u>									
13a. FATHER'S NAME <u>Joe Sewell Thompson</u>						13b. MOTHER'S MAIDEN NAME <u>Dorothy May Boennighausen</u>						14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT'S SIGNATURE OR NAME				ADDRESS					
								<u>Joe &amp; Dorothy Thompson</u>				<u>above</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Incompatible with life</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity (24 weeks)</u>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Premature rupture of membranes thru vaginal delivery</u>								INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify)			21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)											
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR											
												<u>7625</u>					
22. I hereby certify that I attended the deceased from <u>Nov 16</u> , 19 <u>54</u> , to <u>Nov 16</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Nov 16</u> , 19 <u>54</u> , and that death occurred at <u>8:10 P m.</u> , from the causes and on the date stated above.																	
23a. SIGNATURE (Degree or title)						23b. ADDRESS						23c. DATE SIGNED					
<u>Mitchell Yarnow M.D.</u>						<u>2500 Woodson Rd</u>						<u>Overland, 11-20-54</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify)			24b. DATE			24c. NAME OF CEMETERY OR CREMATORY			24d. LOCATION (City, town, or county) (State)								
			<u>11-30-54</u>			<u>Anatomical Board</u>			<u>St. Louis, Mo.</u>								
DATE REC'D BY LOCAL REG. NOV 30 1954			REGISTRAR'S SIGNATURE <u>Carl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland - New</u>			ADDRESS <u>4404 Manchester</u>								

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....

Student Embalmer

Signed.....

Licensed Embalmer No. ....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.